TOTALLY DISABLED EMPLOYEE OR DEPENDENT INFORMATION REQUEST

A **Totally Disabled Subscriber** is a subscriber who, because of illness or injury, is unable to work for income in any job for which he/she is qualified or for which he/she becomes qualified by training or experience, and who is in fact unemployed. A **Totally Disabled Member** is a family member who is unable to perform all activities usual for persons of that age. A **Totally Disabled Retiree** is a retiree who is unable to perform all activities usual for persons of that age.

Employer Group Name: _____

Blue Cross Effective Date: _____

Employee Social Security Number: _____

Disabled Person's Name: _____

Eligibility Status: Employee _____ Dependent _____

Was the Disabled Person continually covered in the six months immediately prior to becoming eligible for this plan, under any public or private health care coverage (including Medical or individual coverage)?

Yes _____ No _____

Prior Medical Insurance Carrier: _____

Date Disability Began: _____

Date Last Worked: _____

Is Disabled Person Hospitalized or Home Confined (Explain): _____

_____

_____

Disabling Condition/Diagnosis: _____

Prognosis: _____

Plan of Future Treatments: _____

Claims Paid During Last 12 Months: _____

Estimated Claims Next 12 Months: _____

Please answer the following questions to enable us to better assist you transition your care and/or provide you with a case manager or offer to enroll you in a preventive care program:

1. Have you ever been told by a health care professional (a doctor or a nurse) that you have heart problems; for example angina, a heart attack, or heart failure?

Yes _____ No _____

2. Have you ever been told be a health care professional that you have diabetes?

Yes _____ No _____

3. Have you ever been told by a health care professional that you have asthma?

Yes _____ No _____

Please Attach This Completed Information Request With Employee's Enrollment Application

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4. Are you pregnant?

Yes _____ No _____

5. Have you ever been told that you may need a transplant at some time in the future?

Heart Lung Liver Bone Marrow Kidney Kidney/Pancreas

6. Have you been hospitalized during the past year?

Not at all One time Two or three times Four to six times More than 6 times

Additional Information or Comments: _____

Attending Physician Statement Attached? Yes _____ No _____

Information Supplied By: _____ Date: _____

Completed / Submitted By: _____ Date: _____

www.bluecrossca.com

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